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The criminalisation of HIV transmission

Liz Shaw, Catherine Butler and Eamonn Rodohan report on the conference held by the Faculty of HIV and Sexual Health held in London on 19 May

The British Psychological Society recently asked the Faculty of HIV and Sexual Health to produce a response to the Department of Health's proposed HIV-related stigma and discrimination action plan. The Faculty, in turn, coopted Paul Flowers to write that response. He suggested that the plan did not adequately address the social impact that the criminalisation of HIV transmission might have.

Paul's comprehensive response coincided with recent interest in the issue amongst Faculty members and staff working with HIV positive clients. Clients have been discussing their concerns about the possibility of being prosecuted as a result of non-disclosure of HIV status with sexual partners. There are also concerns that there may be implications for clinicians over what we document or discuss with clients. So far there have been only seven prosecutions, with possibly another 15 in the pipeline in England and Wales yet discourse about criminalisation resulting from the transmission of HIV as a possibility does seem to be on our agenda.

Different professional bodies, such as British HIV Association, and the Crown Prosecution Service (CPS) have responded to these recent prosecutions by developing medico-legal guidance for professionals. The Faculty of HIV and Sexual Health thought it would also be beneficial to develop guidelines for psychologists working with clients who might be affected by these discourses. To do this we held a conference to explore the reality of these newly emerging social constructs around norms and expectations of HIV status disclosure. This allowed us to present our thinking on the content of guide-

lines from the Society and raise psychologists' awareness of these issues.

The morning session saw speakers looking at the phenomena from client, legal and ethical/clinical perspectives: the afternoon involved delegates getting to grips with the draft guidance for psychologists, followed by discussion workshops to comment on them and explore and digest the issues. The aim of the day was to produce DCP-endorsed guidance that could be available for psychologists on the Faculty webpages.

The first presenter was Matthew Weait, lecturer in law at Keele University. He set the wider context that HIV has always been 'politicised and juridified' as a result of the strong reactions it engenders, for example in sex education, immigration law and the civil liability of health professionals. Cases involving transmission have been brought under the Offences Against the Persons Act (1861), where a person can be charged with 'intentionally or recklessly causing grievous bodily harm'. This applied in all seven cases where there was a conviction as a result of 'recklessly' transmitting HIV to their sexual partners. This means they had to take conscious and unjustifiable risks, given their existing knowledge and understanding of those risks. Only willing and conscious consent can provide a defence in such cases, which means that 'only verbal disclosure of HIV status is a defence. The law is not interested in motivations for non-disclosure, such as fear of violence, rejection, loss of support and isolation, that we commonly encounter with people with HIV. It is also not interested in sexuality, circumstances, gender or ethnicity.

Matthew suggested that the law is ill equipped to deal with the complexities of sexuality and sexual behaviour, disclosure and consent. If heeded, people may then wrongly assume that disclosure is equivalent to consent or assume that if someone has not disclosed that they are negative. The implications for health professionals include that safer sex advice can provide the basis for a criminal prosecutors case. People may then fear that information they provide may be used against them and possibly choose not to access health services or access them and not tell the truth. As HIV must be principally understood as a public health issue, these factors could impede the management of the epidemic and the care and treatment of people living with HIV and AIDS.

Ed Beltrami, Chief Crown Prosecutor for Wales, then provided the picture from the CPS and complainants' point of view. He said that each case was judged on its merits and that the CPS was drawing up guidance suggesting the use of specialist prosecutors and sensitive handling of the cases. He described the process of litigation and suggested advising patients to disclose to partners and use a condom. However, Ed noted that advising someone to use a condom may not be enough for them to avoid prosecution, as it is not seen as a significant factor in the defence on its own. There have so far been no prosecutions of clinicians who might have known someone's HIV status and not disclosed to partners of their patients. However, he suggested professional best practice guidelines were always held in regard by the law as a defence if followed.

Catherine Dodds, a research fellow at Sigma research and author of a briefing paper on grievous harm, then described her research. She interviewed 125 people with HIV about their thoughts and fears about the recent prosecutions. There were worries that it may increase discrimination towards positive people, as they will be expected to take more responsibility and blame for their behaviour than negative people. They saw it as another burden for their lives, which were already plagued by discrimination. Respondents also com-

mented that they did not find media coverage helpful in terms of helping them know what to do to avoid prosecution. Prosecutions were seen to contradict the public health message of shared responsibility for sex risks and turned harm reduction on its head (which promotes confidential testing and advising about safer sex, to use condoms every time and that you don't have to tell a sexual partner your HIV status).

Jim McManus, the assistant director of public health for Barking & Dagenham Primary Care Trust, looked at the issues in this debate from an ethical point of view. He suggested five principles were needed to help guide us: respect for patient autonomy, beneficence, non-maleficence, justice and to see the person with HIV as not the only moral agent. These could then be placed either in a hierarchical or dynamic tension model if a psychological ethics approach were used. However, it does not include the need to act 'prudently or probably' by backing up your actions with trusted advice and applying heuristics based on sound opinion and evidence.

Jim suggested the implied ethical duties of a clinician thinking of disclosing a client's HIV status would be to disclose only if there were significant risks to others or self and if there was refusal to disclose by the client. In these instances, in terms of autonomy you would give a person due notice and a chance to disclose, in terms of non-maleficence you would advise them to seek legal advice, and in terms of beneficence you would have to consider what the effects of disclosing too readily would be.

In the afternoon a draft of guidance for psychologists was presented by its main author, Alex Accoroni. Following this, workshops were held to discuss delegate's experience of case management around HIV transmission in the light of the legal and ethical concepts from the morning, and the feedback produced suggestions for additions to the draft guidance. As this issue is by no means uncontroversial, there was some debate about issues such as whether we should be carrying on business as usual and not respond to a low prevalence event as already covered by DCP ethical guidance on confidentiality. Alternatively, should we produce a document with legal definitions and back-covering suggestions in the rare case that a client might take you to court for not disclosing to them your knowledge of their partner's status or notes are subpoenaed? Issues of language and political usage of the document were discussed since, from a public health point of view, reckless transmission of HIV may best be prevented by counselling and advice rather than punishment.

For any guidance document to be credible to courts and useful to clinicians it needs to be grounded in the reality of evidence. Our next step will be to collate the conference feedback, revise the guidelines accordingly and pass it on to the Society's legal advisers.

Our feeling, and that reflected in the evaluation forms, is that it was a useful and

stimulating day for those who attended. It allowed both a practical review of our practice, for example around documentation and space to explore and consider the ethical and moral issues that are always present when thinking about sexual behaviour. Speakers' presentations will shortly be available on the HIV and Sexual Health Faculty website, as will the guidelines when they are completed. Look out for announcements in the HIV and Sexual Health Faculty newsletter.

At the end of the workshop, Eamonn Rodohan (a trainee clinical psychologist at the University of Hertfordshire) outlined his doctoral research project that will examine therapists' perceptions of the impact of the criminalisation of HIV transmission on their therapeutic practice. The project will explore the professional and service issues that arise for psychologists working with clients in this context, as well as how these new considerations have (or may) impact upon the therapeutic alliance. As well as a survey of applied psychologists within the DCP membership, during the summer Eamonn will be facilitating a number of focus group around the country with psychologists working in sexual health services. If you are a clinical or counselling psychologist working with HIV/sexual health services and would be interested in taking part, please contact Eamonn (E.P.Rodohan@herts.ac.uk) or his research supervisor Liz Shaw (Elizabeth.shaw@beh-mht.nhs.uk).